STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 85765-001**

v

Blue Care Network of Michigan
Respondent
_____/

Issued and entered
this 8th day of November 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On October 16, 2007, XXXXX (Petitioner) filed a request for expedited external review with the Commissioner of the Office of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. In order to receive an expedited external review under PRIRA, a physician must substantiate that the Petitioner's life or health would be seriously jeopardized or the Petitioner's ability to regain maximum function would be jeopardized if an expedited review is not granted. In this case, a physician has not documented such conditions, as required under PRIRA. On October 17, 2007, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The issue in this matter can be resolved by analyzing the Blue Care Network (BCN) BCN10 certificate of coverage, the contract defining the Petitioner's health benefits. It is not necessary to obtain a medical opinion from an independent review organization. The Commissioner reviews contractual issues under MCL 500.1911(7).

II

FACTUAL BACKGROUND

Petitioner is a resident of XXXXX, Michigan. She has reported a variety of physical complaints which have not been definitively diagnosed. She has been seen by her primary care physician and a Michigan oncologist. She has requested a consultation at the XXXXX in XXXXX. (Petitioner has a second residence in XXXXX, XXXXX and saw a physician at the XXXXX in XXXXX in February 2007. BCN did not provide coverage for this care.) Neither of the XXXXX locations is in BCN's network of providers. BCN denied the request. The Petitioner exhausted BCN's internal grievance process and received its final determination letter dated October 11, 2007.

III
ISSUE

Did BCN properly deny the Petitioner's request for coverage for a consultation from an out-of-network provider?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says she is feeling worse and no one can tell her what is wrong. The Petitioner says that for over 7 months she has consulted with several doctors and no one can tell her why her health is getting worse. She says, "if something is not done soon I truly feel I will die!"

Petitioner went to her primary care physician, Dr. XXXXX, for depression, anemia, and insomnia. She was examined September 6, 2007 and Dr. XXXXX recommended continuing her existing treatment. He noted that her chronic neutropenia might be a "preleukemic phenomenon" and recommended additional tests which were conducted in late September and early October. In early October, Petitioner was examined by Dr. XXXXX, a hematology/oncology specialist at the XXXXX who reported that she had unexplained

abdominal pains, possible left ovarian enlargement, and borderline enlarged spleen. In his plan dated October 9 he included the comment "consult again at XXXXX (10/29/07)." A statement Dr. XXXXX sent to the Commissioner on October 16, 2007 included the following remarks:

> [Petitioner] has persisted with functional decline, progressive fatigue and severe upper abdominal pains, in the subxyphoid area. They did not really seem to directly relate to food intake or bowel movements. She has prior EGD, and colonoscopy 3/23/07 that were reported negative, as well as a small bowel follow-thru study. On 10/2/07 repeat CTs no longer noted the borderline nodes, but did suggest possible left ovarian abnormality. US described a 2.7 cm "somewhat nodular ovary that cannot exclude neoplasm."
>
> IMPRESSION: neutropenia, anemia, and abdominal pains, 9# weight loss: unclear etiology left ovarian cystic enlargement r/o CA.
>
> PLAN: re-consult XXXXX (no GYN oncology in XXXXX)

Petitioner argues BCN should cover the requested consultation at the XXXXX in XXXXX since Dr. XXXXX made that recommendation.

Respondent's Argument

BCN's final adverse determination stated:

> The panel has denied your request. They confirmed that our members are required to use in-network resources when available. The documentation submitted does not support that the requested services are not available in network, or that you have been evaluated by our contracted tertiary centers, such as XXXXX, XXXXX, or XXXXX.

BCN says its denial is consistent with its certificate, which requires members to use network providers when available.

Commissioner's Review

The issue in this case is whether BCN properly denied coverage for services from the XXXXX, a provider who is not in BCN's network. The certificate describes the requirements for receiving coverage for services from a non-network provider:

> ***2.01 Unauthorized and Out-of-Plan Services***

> Except for emergency care as specified in Section 1.05 of this booklet, health, medical and hospital services listed in this Certificate are covered **only** if they are:
>
> - provided by a BCN-affiliated provider.
> - preauthorized by BCN.
>
> Any other services will not be paid for by BCN either to the provider or to the member.

These requirements are typical of managed care contracts. BCN is a health maintenance organization (HMO). A fundamental premise of HMOs is the centralization of health care delivery within a network of providers who sign contracts and agree to accept negotiated rates. The negotiated rates are a primary method of containing costs that ultimately benefits every member. If an HMO member uses an out-of-network provider, payment may be greatly reduced or even excluded entirely by the HMO.

While it is understandable that the Petitioner wanted to receive care at a facility recommended by her oncologist, her certificate of coverage requires that she receive services from providers within the network unless out-of-network care is authorized by BCN. No such authorization was made in this case. In addition, there is no evidence in the record that the requested services could not be provided within BCN's network. The Petitioner has seen her primary care physician and other providers, but she has not seen any physician at one of BCN's contracted tertiary centers such as the XXXXX, the XXXXX, or XXXXX. While it may be correct, as Dr. XXXXX indicated, that there is no gynecological oncology in XXXXX, it has not been established that these services are not available elsewhere in the BCN network.

The Commissioner finds that BCN has properly applied the provisions of its Certificate in this case.

V
ORDER

The Commissioner upholds BCN's October 11, 2007, final adverse determination. BCN's denial of coverage for services obtained from a non-network provider is in accordance

with the terms of its certificate.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.